Conclusions: rVAAs have significant mortality. Open or endovascular interventions are equally durable, but endovascular interventions for rVAA result in lower morbidity and mortality. Aggressive treatment of pseudoaneurysms is electively recommended at diagnosis, regardless of size.

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VS2.

TEVAR, EVAR, Endovascular Septectomy, and Chimneys for Managing Complex Thoracoabdominal Aortic Dissection and Aneurysms

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Background: Endovascular therapy for treating complex thoracoabdominal aortic dissections with aneurysmal degeneration is riddled with challenges of inadequate false lumen exclusion and thrombosis, inadequate proximal and distal landing zones with septum dividing the true and false lumen, and the potential for visceral malperfusion. This movie presentation will focus on a stepwise approach to managing complex thoracoabdominal dissections and aneurysms with advanced imaging, thoracic endovascular aortic repair (TEVAR), endovascular aneurysm repair (EVAR), in situ fenestrations, endovascular septectomy, and chimneys as necessary adjunctive techniques for successful thoracoabdominal dissection and aneurysm exclusion and visceral perfusion.

Technical description: Patient presented with chronic thoracoabdominal aortic dissection from left subclavian to iliac bifurcation with 6.5-cm thoracic aneurysm and 6-cm abdominal aortic aneurysm (AAA). Underwent TEVAR and false lumen coil embolization for complete false lumen exclusion. EVAR was planned several months later. The juxtarenal and infrarenal aorta had a chronic aortic septum with distinct separation of true and false lumens, prohibiting an adequate proximal stent graft landing zone at the intrarenal aortic neck. True and false lumens were accessed, and an endovascular septectomy was performed across a fenestration at the level of the infrarenal aortic neck to create an adequate proximal stent graft landing zone for successful EVAR. Patient subsequently presented with juxtarenal 7.8 cm AAA with a true lumen pedicle perfusing all visceral vessels. Patient underwent TEVAR bridging the thoracic and abdominal aortic stent grafts and a chimney to the pedicle perfusing all visceral vessels, and complete aneurysm exclusion. At 1 year postoperatively, patient is doing well, with complete thoracoabdominal aortic aneurysms exclusion.

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SS9.

Vascular Reconstruction plays an Important Role in the Treatment of Pancreatic Adenocarcinoma

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Objectives: Previous studies have proven the feasibility of performing a pancreaticoduodenectomy (Whipple) in patients with portal veinn/superior mesenteric vein (PV/SMV) or arterial invasion. We report our institutional experience with the use of a variety of vascular reconstructive methods during pancreatic resections for adenocarcinoma.

Methods: A retrospective review was performed identifying all Whipple and total pancreatectomy patients from January 2003 through February 2013. All venous (PV/SMV) and arterial (SMA/hepatic) reconstructions were extracted and reviewed to determine survival and perioperative complications.

Results: During the 10-year study period, 270 Whipple and total pancreatectomy procedures were performed, of which 183 were for adenocarcinoma of the pancreas. A total of 60 of 183 (32.8%) vascular reconstructions were found, 49 venous and 11 arterial. Venous reconstruction included 37 (61.7%) primary repairs, 4 (6.7%) reconstructions with cryovein, 3 (5.0%) repairs with autologous vein patch, 3 (5.0%) autologous saphenous reconstructions, and 2 (3.33%) portocaval shunts. Additionally, there were 11 (18.3%) arterial reconstructions (seven hepatic artery and four superior mesenteric artery). There was one perioperative death (1.7%). One-year survival for all reconstructions was 70.3%, which is equivalent to T3 lesions that did not receive vascular reconstruction (72.6%), with a median survival time of 515 days and 12 patients still alive. Survival time was comparable with each type of venous reconstruction, averaging 528 days (11 of 49 patients still alive). Of the venous reconstructions, four of 49 (8.2%) resulted in PV thrombosis, three within the primary repair group and one delayed thrombosis within the cryovein group. There was no thrombosis in any patients after arterial reconstruction.

Conclusions: An aggressive approach for stage II pancreatic cancers with venous or arterial invasion can be performed with comparable results when executed by an experienced institution with skilled oncologic and vascular surgeons.

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